

IN THE

CLERK

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of
New York; GEORGE E. PATAKI, Governor of the State
of New York; and ROBERT M. MORGENTHAU,
District Attorney of New York County,
Petitioners,
v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,
Respondents.

STATE OF WASHINGTON; CHRISTINE O. GREGGORE,
Attorney General of Washington,
Petitioners,
v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

On Writs of Certiorari to the
United States Courts of Appeals
for the Second Circuit and
for the Ninth Circuit

BRIEF AMICUS CURIAE FOR THE
NATIONAL HOSPICE ORGANIZATION
IN SUPPORT OF PETITIONERS

ANN MORGAN VICKERY
E. BARRETT PRETTYMAN, JR.*
CHRISTOPHER S. YOO
HOGAN & HARTSON L.L.P.
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5685

* Counsel of Record

Counsel for Amicus Curiae

QUESTION PRESENTED

Are laws prohibiting physician-assisted suicide justified
by legitimate state interests?

(i)

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Nos. 95-1858 and 96-110

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BRIEF AMICUS CURIAE FOR THE
 NATIONAL HOSPICE ORGANIZATION
 IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

The National Hospice Organization ("NHO")¹ is a non-profit, public-benefit, charitable organization dedicated to promoting and maintaining quality care for the needs of terminally-ill persons and their families. Established in 1978, NHO currently represents more than 2,200 hospice programs and 47 state hospice organizations, as well as over 4,000 hospice professionals and supporters.

NHO's organizational mission is to enhance the end of life for people dying in America by ensuring access to quality hospice care. Hospice, in this context, refers not to a place, but rather to a program of care, based on a philosophy that recognizes dying as part of the normal process of living and focuses on enhancing the quality of remaining life. As a central tenet, the hospice philosophy affirms life and seeks neither to hasten nor to postpone death.

A hospice is a coordinated health care program that provides palliative and supportive care to terminally-ill patients and their families, twenty-four hours a day, seven days a week, at home or in home-like facilities. With a focus on enhancing the quality of life for both the patient and the family, hospices provide physical, social, spiritual, and emotional care, using a medically-directed interdisciplinary team consisting of professionals and volunteers. A typical hospice team includes a hospice physician; the patient's attending physician; and one or more nurses, social workers, pastoral or other counselors, home health aides, and volunteers.²

¹ This brief is being filed with the consent of the parties, whose letters of consent have been filed with the Clerk of the Court.

² Hospice care is a covered benefit under Medicare, 42 U.S.C. § 1395x(dd), as well as under most other public and private health insurance programs. The Medicare definition of hospice care and conditions of participation for hospice programs form the basis

In order to help patients make the most of the time that remains to them, hospices establish pain control and symptom management as clinical goals. Moreover, hospices understand the need to treat patients' emotional needs as well as their physical requirements and recognize that psychological pain is as significant as physical pain.

Hospices are unique in that they include the patient's family and friends within the unit of care and help family members as an essential part of their mission. Accordingly, hospices provide a wide variety of support for family members and friends while their loved one is dying, as well as bereavement care after the person has died.

The hospice philosophy also affirms the right of those who are dying to make as many choices as possible for themselves—both in living what is left of life and in dealing with fatal illness. An important component of hospice care, therefore, is enhancing the ability of patients to control their lives for as long as possible, even in the terminal phase of their illness. Accordingly, NHO has supported the right of terminally-ill patients to refuse intrusive, life-prolonging treatment or nourishment. Dying patients must have the right to make the choice to refuse interventions designed to prolong the dying process.

NHO does not, however, agree with the courts below that because States must allow terminally-ill people to refuse such unwanted treatments, they must also allow physicians to assist terminally-ill patients to end their lives by suicide. Hospice professionals, who deal with dying patients every day, see these issues as presenting very different risks and benefits to the terminally ill, their families, and society at large.

for many state licensure laws and are consistent with NHO's Standards for a Hospice Program of Care.

NHO recognizes that the vast majority of people in this country have strong feelings about issues relating to death. It is a subject affecting us all, and our views are likely to be colored by introspection and fear. It is for that very reason that we must be extremely careful that we use the proper standard for determining the legitimacy of a legislature's conclusions. We should ask ourselves not whether a dying individual has a right, uninhibited by legislative intervention, to choose to have a doctor assist in his suicide, but rather whether the State has a legitimate interest in seeing to it that its citizens be given every opportunity to decide to live, unimpaired by such factors as pain and depression.

It is important, therefore, that this Court be fully aware of a middle ground available between the two extremes of physician-assisted suicide and a death devoid of peace and dignity. In that middle ground is hospice. Without statutes such as those at issue in this case, hospices will have no opportunity to assist persons who simply wish to die become persons wishing to live until they die.

SUMMARY OF ARGUMENT

The decisions below failed to appreciate that the final stage of life presents opportunities for meaningful experiences that could be lost without the State's protection of life and prevention of assisted suicide even among the terminally ill. Moreover, many terminally-ill patients seek assistance with suicide not because they cannot be cured, but rather because they cannot bear the physical pain and depression that often accompany terminal illness. These factors can almost always be ameliorated.

Hospice care provides a proven, effective alternative to assisted suicide that is ideally suited to ameliorate the factors underlying the desire for suicide among the terminally ill. By emphasizing palliative care, the hospice

movement has succeeded in increasing awareness in the medical community of the need to treat pain and symptom management aggressively. Furthermore, hospices understand the psychological dimension of suffering and are committed to treating the depression and fear that surround terminal illness. When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide generally disappears. Hospices provide substantial benefits to the patients' families as well, by including them in the unit of care and by providing them with the counseling, support, and anticipatory grief work that has proven so effective in softening the blow of a loved one's death. Like hospices, States can legitimately place value on the end of life by refusing to support the practice of physician-assisted suicide.

States are also justified in retaining the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The medical literature does not support the confidence of the courts below in the ability of medical professionals to distinguish between those who are and are not in the final stages of a terminal illness, and errors in prognosis would have tragic consequences if they were to form the basis for assisted suicide. Abandoning the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment would also thwart recent efforts to increase awareness in both the medical community and the public of the benefits of the comprehensive program of palliative and supportive care offered by hospices. Finally, acceptance of assisted suicide among the terminally ill would place hospices and other health care providers in an untenable position by diminishing the level of trust between the health care provider and patient that is critical to the provision of effective care. Given the adverse consequences that would flow from the recognition of a right to assisted suicide, this Court should adhere

to the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment.

ARGUMENT

I. THE COURTS BELOW DISMISSED THE STATES' INTEREST IN PRESERVING LIFE BY FAILING TO CONSIDER THE OPPORTUNITIES TO FIND VALUE DURING THE LAST STAGE OF LIFE.

While recognizing the State's interest in preserving the lives of all its citizens, the courts below found that this interest was attenuated when the lives being preserved suffered from terminal illness. As the Second Circuit reasoned:

[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? * * * The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

No. 95-1858 Pet. App. 31a (citation omitted). Similarly, the Ninth Circuit found the State's interest in preventing suicides to be "substantially diminished in the case of terminally ill, competent adults who wish to die." No. 96-110 Pet. App. A-73 to A-74. The Ninth Circuit concluded that under such circumstances "the state's interest in preventing such individuals from hastening their deaths [was] of comparatively little weight." *Id.* at A-74; see also *id.* at A-89 (reasoning that the state interest in protecting family members and loved ones "is of almost negligible weight when the patient is terminally ill").

What the courts below failed to recognize is that the final stage of life may be a time of profound opportunity for terminally-ill individuals and their families. The hospice experience has taught that life is not "all but ended" simply because a person suffers from a terminal illness,

nor does "the potential for life diminish[]." Dying is an intrinsic part of being human, and like life's other phases, dying offers unique challenges and opportunities. Given proper support, dying can become an important, valued *life* event. As one commentator has noted, "However diminished the body and however changed the life circumstances in later life, the mind and spirit can still flourish. At all stages of life, even as we are sick and dying, we have the capacity to set new goals, redefine the self, and find valid meaning and integrity in our existence." Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 Issues L. & Med. 415, 433 (1995); see also Ira R. Byock, *The Nature of Suffering and the Nature of Opportunity at the End of Life*, 12 Clin. Geriatric Med. 237, 248 (1996).

By treating the end of life as meaningless, the courts below adopted an unnecessarily static view that is unable to accommodate the changing nature of life and of the self. Osgood, 10 Issues L. & Med. at 433. Had these courts acknowledged that dying is a part of the normal process of living and that like all of life's stages it presents substantial opportunities for personal growth and development, they would have recognized that the State has an interest in preserving life even in the face of terminal illness. Instead, the courts below adopted a view of dying which admitted only two possibilities: unrelieved misery or assisted suicide. As the Ninth Circuit reasoned, when all that lies ahead is "debilitating pain and a humiliating death, the decision to commit suicide is not senseless." No. 96-110 Pet. App. A-74. This truncated view of dying ignores the fact that it is almost always possible to ameliorate the factors underlying the desire for suicide among the terminally ill.

Numerous studies have documented that uncontrolled pain is a major risk factor for suicide among the terminally ill. See, e.g., Susan D. Block & J. Andrew Bill-

ings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2040 (1994); see also *Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcomm. on the Const. of the House Comm. on the Judiciary*, 104th Cong., 2d Sess. 10 (1996). Sadly, although such physical suffering can almost always be alleviated, until recently physical pain has been woefully undertreated in this country. See, e.g., Block & Billings, 154 Archives Internal Med. at 2040; Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-293 (1991); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1124 (1996).

Indeed, the undertreatment of pain in terminally-ill patients was one of the factors underlying the development of the first American hospices in the early 1970's. In the intervening decades, however, not only has the hospice movement spread throughout the United States, but, more recently, the organizations that set standards for the practice of medicine have embarked on efforts to educate doctors about palliative care techniques and to encourage appropriate treatment of pain and other symptoms, with the end result that pain should no longer be a cause for ending one's life. Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 9: Management of Cancer Pain* (1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency—Educational Resources Document* (1996).

Depression is another factor that renders terminally-ill patients vulnerable to thoughts of assisted suicide. See, e.g., William Breitbart et al., *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 239, 241 (1996); Foley, 6 J.

Pain & Symptom Mgmt. at 294-295; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, Hastings Ctr. Rep., May-June 1993, at 32, 38. When depressed, people lose the ability to compare suicide with alternative solutions or with the prospects for a meaningful future. Thus, victims of depression quickly view their problems as unresolvable and are led to thoughts of escape through death. Furthermore, depression exaggerates the tendency to see the world in black and white terms and encourages the adoption of extreme solutions, such as suicide. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 119 (1985); Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 Issues L. & Med. 123, 134 (1994); Osgood, 10 Issues L. & Med. at 428. Such depression is readily treatable, see, e.g., Block & Billings, 154 Archives Internal Med. at 2042; Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 New Eng. J. Med. 1100, 1101 (1991), and the typical primary care physician who heretofore has been ill-equipped to recognize treatable depression among the elderly and the terminally ill is now being trained to offer just such relief, see, e.g., Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 5: Depression in Primary Care* (1993).

The treatment of the pain and depression accompanying terminal illness is an important focus of hospice professionals' work. They also deal, however, with a number of other fears associated with terminal illness in the minds of most Americans.⁸ An important component of

⁸ At the request of NHO, the Gallup Organization recently surveyed a national sample of Americans on their knowledge and attitudes related to hospice care. One of the questions asked about fears associated with death. While one in seven (14%) mentioned the pain associated with dying, four in ten (40%) said that being a burden to family and friends was their greatest fear. Other fears included lack of control (8%) and losing one's dignity (8%). *The Cutting Edge: Vital Statistics*, Wash. Post, Oct. 8, 1996, at Z5.

a hospice team's role is to help the patient and family understand the progression of the patient's disease, so that changes are not unexpected and plans can be made, increasing the sense of control that is so important to well-being. By training families and other caregivers and supporting them in their care of the patient through respite care and the assistance of volunteers, hospices help to reduce the burden of caring for a dying relative or friend. Through hospice care, families and loved ones may also benefit from interacting with others facing the same predicament. Daryl J. Miller, *Legal Killing: The Imminent Legalization of a Physician's Affirmative Aid-in-Dying*, 34 Santa Clara L. Rev. 663, 703 (1994) (citing Milton D. Heifetz & Charles Mangel, *The Right to Die* 164 (1975)). Counselors may also use this final phase for anticipatory grief work to help prepare for the sense of loss that accompanies the death of a loved one. *Id.*; Elliott J. Rosen, *Families Facing Death: Family Dynamics of Terminal Illness* 97 (1990); J. Eugene Knott & Eugenia Wild, *Anticipatory Grief and Reinvestment, in Loss and Anticipatory Grief* 55, 57-59 (Theresa A. Rando ed., 1986). But most importantly, hospices can allow patients and their families to use the process of dying as an opportunity to resolve outstanding issues. There are countless stories of how families have used life's final stage as the chance to complete social roles and responsibilities, to reconcile previously strained relationships, and to deepen intimate relationships even further. See, e.g., Rosen, *supra*, at 96; Ira Byock, *Dying Well: The Prospect for Growth at the End of Life* (forthcoming 1997) (copy lodged with the Clerk of the Court). As one commentator has noted, "Making the patient whole again and bringing families together at the bedside is what hospice does best." Miller, 34 Santa Clara L. Rev. at 703 (citing Jack M. Zimmerman, *Hospice: Complete Care for the Terminally Ill* 45 (1981)).

The real proof of hospice as a preferable option for care of the terminally ill lies in the results. The evidence demonstrates that when terminally-ill persons who re-

quest assistance with suicide are treated for depression and are given proper palliative and supportive care, they tend to change their minds about assisted suicide. David Cundiff, *Euthanasia Is Not the Answer: A Hospice Physician's View* 23-24 (1992); New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 26 (1994); Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 531-532, 537 (1994); Hendin, 10 Issues L. & Med. at 164; Osgood, 10 Issues L. & Med. at 429. When physical and psychological suffering are successfully addressed, the patient becomes free to pursue the greatest amount of personal fulfillment possible in his or her remaining life.⁴

In this sense, terminally-ill individuals who seek assistance with suicide are not that different from "the depressed twenty-one year old, the romantically devastated twenty-eight year old, [and] the alcoholic forty-year old" whose

⁴ Dr. Herbert Hendin, Executive Director of the American Suicide Foundation, recounts the story of a patient named Tim who was given a 25% chance of survival and who was referred to Dr. Hendin for psychiatric consultation:

His immediate reaction was a desperate preoccupation with suicide and a wish for support in carrying it out. At first he could not consider how he felt about death and its meaning to him but remained preoccupied with concerns about being dependent and unwilling to tolerate the symptoms of his disease or the side effects of proposed treatment. Once we could talk about the possibility or likelihood of his dying * * *, his desperate avoidance subsided. He decided to undergo medical treatment, complained relatively little about the unpleasant side effects, and used the remaining months of his life to connect with his wife and parents in ways that were moving and meaningful for him. Two days before he died, Tim talked of what he would have missed without the opportunity for a loving parting.

Hendin, 10 Issues L. & Med. at 128. Similar stories are recounted elsewhere. See, e.g., Marzen, 24 Duquesne L. Rev. at 132-133; Byock, 12 Clin. Geriatric Med. at 245-246; Byock, *Dying Well*, *supra*.

suicides the Ninth Circuit acknowledged would be senseless. No. 96-110 Pet. App. A-74 (internal quotation marks omitted). As that court conceded, "the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated." *Id.* at A-73. Thus, according to the Ninth Circuit's own logic, the fact that the factors that cause the terminally ill to consider seeking assistance with suicide, such as pain and depression, can be treated is enough to justify the State's prohibition of it. In the vast majority of cases, overturning the state bans on assisted suicide in the name of personal dignity or autonomy, simply because certain people want it, is no more defensible than permitting the depressed twenty-one year old, the romantically devastated twenty-eight year old, and the alcoholic forty-year old to commit suicide. The fact that some people may truly want physicians to help them kill themselves is beside the point. As one commentator noted, "The acceptance of euthanasia for psychiatric patients who are suicidal is simply bad psychiatry. * * * Seriously suicidal patients want suicide. In a society that makes euthanasia accessible for them they will be harder to treat, not easier." Hendin, 10 Issues L. & Med. at 164.

Had the Courts of Appeals understood that "[t]he hospice way of dying * * * offers a middle path between two undesirable approaches in caring for the terminally-ill patient—curative, high-technology medicine on one hand, and death by euthanasia on the other hand," Courtney S. Campbell *et al.*, *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Ctr. Rep., May-June 1995, at 36, 37, they never would have felt constrained by the false dichotomy represented by those two options. Hospice offers patients and their families the opportunity to deal with the pain, depression, and other experiences caused

by dying and—unlike the alternative of physician-assisted suicide—gives them the opportunity to continue to live.⁸ In light of the availability of hospice care as a means to alleviate the physical and psychological suffering that underlies terminally-ill patients' desire for assistance with suicide and the potential benefits to the patients' families, the States of Washington and New York were more than justified in concluding that their interest in preserving life was just as strong during the last stage of life as it was during all of life's other stages.

II. STATES ARE JUSTIFIED IN DISTINGUISHING BETWEEN ASSISTED SUICIDE AND THE WITHDRAWAL OF LIFE-PROLONGING TREATMENT.

The courts below also erred in challenging the legitimacy of the historical distinction between assistance with suicide and the withdrawal of life-prolonging treatment or nourishment. See No. 95-1858 Pet. App. 29a-34a; No. 96-110 Pet. App. A-76 to A-82. In discarding this distinction, the courts below overlooked the legal basis and the practical benefits of this doctrinal line. Moreover, the line that the courts below adopted in place of this distinction—the distinction between terminally ill and non-terminally ill individuals—is fraught with serious practical problems. This Court should adhere to its prior practice of refusing to extend constitutional rights when such an extension would prove unworkable, *see, e.g.*, *United States v. Dixon*, 509 U.S. 688, 711 (1993), and reverse the decisions below.

A. Determining How Long a Terminally-Ill Patient Has to Live Is Notoriously Difficult.

The Ninth Circuit's decision hinged on its conclusion that the State's interests in prohibiting assistance with

⁸ As one hospice patient exclaimed, "I went to the hospital to be cured, and almost died. Then I went into Hospice to die, and lived." See Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 Ohio N.U. L. Rev. 755, 758 (1994).

suicide diminished during "the final stages of an incurable and painful degenerative disease," No. 96-110 Pet. App. A-74, when a patient's "death is imminent," *id.* at A-89.⁶ Similarly, the Second Circuit ruled that it was "during the final stages of a terminal illness" when death is "imminent and inevitable" that the State's interest in preserving life abated. No. 95-1858 Pet. App. 31a.⁷ Although the Ninth Circuit "acknowledge[d] that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence," No. 96-110 Pet. App. A-83, the courts below each expressed their confidence in the medical profession's ability to define terminal illness in such a way that would adequately protect patients from the ill effects resulting from errors in medical and legal judgment. *See id.* at A-83, A-103 to A-104; No. 95-1858 Pet. App. 34a.

Medical research, however, has demonstrated the difficulties that surround any determination of how long a terminally-ill patient has to live.⁸ As medical researchers have noted, "physicians typically make poor judgments about survival in terminally ill patients." Nicholas A.

⁶ As the Ninth Circuit reasoned, it is only during the final stage of life when patients are "no longer able to pursue liberty or happiness," No. 96-110 Pet. App. A-72, and "can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends," *id.* at A-74, that the State's interests in preserving life and preventing suicide recede.

⁷ See also No. 95-1858 Pet. App. 34a (noting that "[t]he plaintiffs seek to hasten death only where a patient is in the 'final stages' of a 'terminal illness'").

⁸ These problems are compounded by the fact that the legal and medical definitions of the term "terminal illness" vary widely depending on the situation, ranging from a diagnosis of a life-threatening or fatal disease to a prognosis of months or weeks to live. The Medicare statute provides that "[a]n individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. § 1395x(dd)(3)(A).

Christakis & José J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172, 176 (1996); see also Robert A. Pearlman, *Inaccurate Predictions of Life Expectancy: Dilemmas and Opportunities*, 148 Archives Internal Med. 2537, 2537 & nn.2-6 (1988); Howard Brody & Joanne Lynn, *The Physician's Responsibility Under the New Medicare Reimbursement for Hospice Care*, 310 New Eng. J. Med. 920, 921 & nn.3-5 (1984); John F. Potter, *A Challenge for the Hospice Movement*, 302 New Eng. J. Med. 53 (1980). Specifically, assessments of a patient's chances for survival are often biased by the attending physician's recent experiences, which can often lead the physician to overestimate or underestimate the importance of a particular variable. Joanne Lynn *et al.*, *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 West J. Med. 250, 251 (1995).

Moreover, the tools of medical prognosis still have yet to account for variations in treatment in an adequate manner. This is particularly problematic because the manner in which the estimate of prognosis necessarily affects treatment options creates a feedback effect that in turn may influence the estimate itself. *Id.* at 256. Such problems are only likely to increase as medical technology continues to improve. Potter, 302 New Eng. J. Med. at 53. Finally, the need for accuracy in such a determination necessarily varies according to the implications surrounding a particular prognosis. Pearlman, 148 Archives Internal Med. at 2537-38. In light of the indeterminacy surrounding the decision as to who is and who is not in the final stages of a terminal illness, the confidence of the courts below in the ability of physicians to apply adequate definitions of terminal illness seems unwarranted.⁹

⁹ In light of these problems, the Ninth Circuit's statement that "should an error actually occur it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most

This Court should avoid the practical difficulties surrounding the definition of terminal illness and should instead base its legal principles on the well-established distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The legal support for the right to refuse life-prolonging treatment has been derived by some courts from the right to privacy (the right to be left alone).¹⁰ Others have based this right on liberty interests (freedom from unwarranted state intrusions into bodily integrity). As this Court observed in *Cruzan*, “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from [this Court's] prior decisions.”¹¹ Indeed, “freedom from unwanted medical attention is unquestionably among those principles ‘so rooted in the traditions and conscience of our people as to be ranked as fundamental.’”¹²

A right to refuse unwarranted invasions of bodily integrity, however, is different from a right to the assistance of a physician in taking one's own life. The first involves protecting oneself against unwanted medical treatment; the second involves enlisting the aid of practitioners to

desirable” seems puzzling. No. 96-110 Pet. App. A-83. How an erroneous determination of terminal illness that wrongly encourages a patient to seek assistance with suicide inures to the benefit of the patient is far from clear.

¹⁰ *Cruzan ex rel. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990) (citing *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body * * *.”)).

¹¹ 497 U.S. at 278; *see also id.* at 289 (O'Connor, J., concurring) (“the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment”).

¹² *Id.* at 305 (Brennan, J., dissenting) (*quoting Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934))).

carry out acts inimical to the physician's purpose and creed. The legal and ethical differences between the two are manifest.

B. Empowering Physicians to End Life Would Irrevocably Change the Way Care Is Perceived and Undermine Hospice Care as a More Appropriate Option for Care of the Terminally Ill.

Ironically, the attempt by the courts below to show sympathy for terminally-ill patients threatens to undercut the ability of hospice care to relieve these patients' suffering. As noted earlier, the medical community has only recently begun to appreciate fully the importance of treating physical and emotional pain and other symptoms aggressively and of providing comprehensive palliative care when cure is not possible. The legalization of assisted suicide would divert attention and support away from these important efforts. *See Chopko & Moses*, 70 Notre Dame L. Rev. at 532; *Miller*, 34 Santa Clara L. Rev. at 704.

An increased focus on assisted suicide as an option would also impede the growing public awareness of the benefits of hospice care. A recent Gallup poll indicated that fully 82% of adults have heard of hospice care, and 88% would choose hospice-style care if they were terminally ill and had less than six months to live. More importantly, the public, when made aware of the kinds of services provided by hospices, prefers hospice care to assisted suicide. The fact that more people indicated a preference for hospice care in this poll, in which the context suggested hospice as an alternative to suicide, than did so in previous surveys that did not mention hospice care as an option further underscores the influence that ignorance about alternatives to assisted suicide has on public attitudes about care for the terminally ill. *See Judy Foreman, 70% Would Pick Hospice, Poll Finds*, Boston Globe, Oct. 4, 1996, at A3.

The acceptance of assisted suicide as a way to deal with terminal illness would undercut further efforts to increase the public's awareness of hospice as a life-affirming option.¹³ States are justified in prohibiting assisted suicide if for no reason other than to avoid the tragedy of having a terminally-ill patient opt for assisted suicide simply out of ignorance about the alternatives.

Finally, the establishment of a constitutional right to assisted suicide would irrevocably distort the picture of end-of-life care so carefully painted by hospices over the last twenty years. If assistance with suicide gains acceptance, some patients may seek such assistance from hospices, forcing hospices to choose between violating their commitment not to abandon any terminally-ill patient and their commitment neither to hasten nor to prolong death. Worse yet, acceptance of assisted suicide might well lead other patients to reject hospice care for fear that such assistance would be urged upon them.¹⁴

The courts below clearly erred in equating physician-assisted suicide with the withdrawal of life-sustaining treatment and the relief of pain. It would be tragic if the population at large were similarly confused. Hospices regularly comply with patients' requests to withhold or

withdraw artificial nutrition and hydration. Hospice physicians also regularly order medications to relieve pain, even when an unintended consequence might be the shortening of a terminally-ill patient's life. As Judge Kleinfeld noted, in labeling the Ninth Circuit's proposition "exactly wrong," "[k]nowledge of an undesired consequence does not imply that the actor intends that consequence." No. 96-110 Pet. App. A-162, A-163 (Kleinfeld, J., dissenting). It is important to hospices that people who approach them during the most difficult times of their lives have no doubt about the intent of the care given them.

Dame Cicely Saunders is the physician who is generally credited with founding the first modern-day hospice, London's St. Christopher's, in 1968. Thousands of hospice professionals and volunteers around the world have repeated her promise to patients: "You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." See Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* 107 (rev. ed. 1992). The National Hospice Organization asks only that this Court continue to value the lives of terminally-ill patients and that this Court recognize the legitimate interests of States in protecting those lives.

¹³ The Netherlands has already witnessed the debilitating effect that tolerance of assisted suicide can have on the hospice movement. Miller, 34 Santa Clara L. Rev. at 663 n.270 (attributing the scarcity of hospices in the Netherlands to "the fact that accepting active euthanasia decreases the incentive to create hospices"); see also Wheeler, 20 Ohio N.U. L. Rev. at 760.

¹⁴ People growing older have almost instinctively honed in on the ways that assisted suicide might undermine the care that otherwise would be available to them. A recent survey shows that elderly persons reject physician-assisted suicide, indicating that it is the people most vulnerable to the misuse of physician-assisted suicide who are most strongly opposed to it. Harold G. Koenig *et al.*, *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives Internal Med. 2240, 2248 (1996).

CONCLUSION

For the foregoing reasons, and for those set forth in the petitioners' briefs, the judgments below should be reversed.

Respectfully submitted,

ANN MORGAN VICKERY
E. BARRETT PRETTYMAN, JR.*
CHRISTOPHER S. YOO
HOGAN & HARTSON L.L.P.
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5685

* Counsel of Record

Counsel for Amicus Curiae